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## Coordination of Benefits Contractor Claims Transition Update

The October 2006 issue of *Update* announced that MassHealth implemented the Coordination of Benefits Agreement (COBA) in September 2006. As part of COBA, the Centers for Medicare & Medicaid Services selected coordination-of-benefits contractor (COBC) GHI to handle the Medicare claims cross-over process.

MassHealth has experienced and still is experiencing problems in processing some of these claims. Due to this processing problem, MassHealth will no longer process translated claims received from GHI for any service denied by Medicare until further notice.

Until further notice, all providers should submit claims denied by Medicare directly to MassHealth using either the appropriate electronic 837 Coordination of benefits (COB) transaction, or on paper following the standard crossover claim procedures. Once issues surrounding COBC/Medicare denied claims have been resolved, MassHealth will resume processing those received from the COBC.

### Institutional Claims

MassHealth stopped processing claims submitted by GHI in October to institute program changes to correct claims paying at zero. This problem was caused by the difference in the companion guide rules between Medicare and MassHealth. MassHealth will begin processing institutional claims, and they will start to appear on remittance advices (RAs) dated

12/19/06. To correct claims incorrectly processed, the provider can submit the adjusted claim(s) electronically or on paper.

If you are approved to submit COB claims electronically, rebill the claim using the 837 Void and Replace transaction and enter the Medicare Payment details. Please refer to the 837 MassHealth Companion Guide, Section 3.3: Detail Data for COB Claims.

To correct the issue on paper, send the adjustment claim, EOMB, MassHealth RA showing the zero payment, and a cover letter to MassHealth at:

MassHealth  
Attn: Adjustments  
P.O. Box 9118  
Hingham, MA 02043.

If MassHealth incorrectly denied the COBC claim, and Medicare made a payment or application to the coinsurance and/or deductible amounts, it can be re-submitted to MassHealth. To correct the issue on paper, follow the standard crossover paper-claim procedure and submit the paper claim(s) and EOMB to the above MassHealth address (substituting "crossover claims" for "adjustments" in the attention line).

### Outpatient Claims Denied for Errors 655 and 089

All claims submitted to MassHealth must have entries for admission hour and type. Claims that do not have an entry for ad-

mission hour and type will be denied for error 655, "Invalid/missing time of entry" (adjust reason and remark code 16-N46 on the electronic 835 remittance transaction) and 089, "The type of admission entered on the claim is invalid" (adjust reason and remark code A1-MA41 on the electronic 835 remittance transaction).

To prevent future denials, be sure to enter a time and type of admission on the claim submitted to Medicare.

To correct the issue electronically, if both Medicare and MassHealth denied the claim, rebill the claim and include an entry with the appropriate code for admission hour and type. The applicable information for electronic claims is in the 837I Implementation Guide on pages 169-172. You should populate Loop 2300 DTP and 2300 CL 1 to avoid receiving errors 655 and 089.

Submitters should use the standard HIPAA-compliant codes found in the 837I Implementation Guide. Please refer to Acute Outpatient Hospital Bulletin 15, Chronic Disease and Rehabilitation Outpatient Hospital Bulletin 2, or Psychiatric Outpatient Hospital Bulletin 1 (January 2006) for more information.

To correct the issue on paper, resubmit the claim to MassHealth and include an entry for Item 18. Applicable codes that can be entered on the paper UB92 are found in Subchapter 5 of your provider manual.

## Dental Program Focused on Increasing Access to Dental Care

The new third-party administrator (TPA) for the MassHealth dental program, Dental Services of Massachusetts (DSM), has a long history of providing oral health care to people both in and out of Massachusetts.

DSM will work through its subcontractor, Doral, one of the nation's leading administrators of Medicaid dental programs, to bring state-of-the-art technology and service standards to dentists participating in MassHealth. The

new effective date of this program change is February 1, 2007.

DSM's objective is to simplify program administration for dentists and provide a supportive infrastructure for members.

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## Optometrists Approved to Administer Eye Exams and Related Treatment Services to MassHealth Essential Members

In October 2006, MassHealth issued Vision Care Bulletin 13. This publication notified providers of the expansion in the types of providers from whom MassHealth Essential members may receive certain covered vision-care benefits. Information in this bulletin is applicable only to services for MassHealth Essential members and does not apply to any other MassHealth coverage type.

MassHealth Essential members are eligible for eye exams and related treatment services. However, the types of providers from whom MassHealth Essential members could receive these benefits were limited.

Effective for dates of service on or after November 1, 2006, covered visual analysis for MassHealth Essential members

(which includes eye exams and supplementary testing) may be provided by an optometrist participating in MassHealth. Visual analysis services provided by physicians and ophthalmologists participating in MassHealth have been covered for MassHealth Essential members since the inception of this eligibility category.

Please note that there will be no change to the range of vision benefits for which

**Vision Care Bulletin 13 is available for download from the MassHealth Provider Library.**

MassHealth Essential members are eligible. This bulletin affects only the types of providers who may bill MassHealth for covered vision services for MassHealth Essential members.

Vision coverage for MassHealth Essential members consists of visual analysis, including eye exams and supplementary testing services. MassHealth Essential members are not eligible for the provision or dispensing of ophthalmic materials such as eyeglasses, contact lenses, or other visual aids.

For more information, please review Vision Care Bulletin 13 in the MassHealth Provider Library. The Provider Library is accessible from the 2006 Provider Bulletins link in the MassHealth Regulations and Other Publications section on [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

## New on [mass.gov/masshealth](http://mass.gov/masshealth)

In November 2006, MassHealth added and updated certain provider tools on the MassHealth Web site. A Guide to the MassHealth Web Site and How to Read Your Provider Manual are two quick reference pages to help you access information you need faster.

### Guide to the MassHealth Web Site

There is a lot of information on the MassHealth Web site, and sometimes it can be overwhelming to find what you need. That is why we have created a quick reference chart to show you where to go on [www.mass.gov/masshealth](http://www.mass.gov/masshealth) to find the information you need at a glance. With all the provider information in [www.mass.gov/masshealth](http://www.mass.gov/masshealth), this chart is a great tool to help you navigate the Web site as efficiently as possible.

To access the chart, click on the Web Site Navigation Tips link under the Information for MassHealth Providers section on [www.mass.gov/masshealth](http://www.mass.gov/masshealth). At the bottom of the page, click on the link for the Guide to MassHealth Web Site, in the Additional Materials section.

We suggest you mark the location of this page in your "Favorites" folder in your browser, or print out a copy of the page for easy referencing.

### How to Read Your Provider Manual

From provider and program regulations to service codes and descriptions to billing instructions and more, a MassHealth provider manual packs in a lot of information. To help you quickly access the topics you need, check out our How to Read Your MassHealth Provider Manual quick reference flyer. This new chart identifies where you can find the most commonly requested provider manual pages for each of the subchapters.

This new flyer is available in the Provider Manuals section of the Provider Library. You can access the Provider Library from the MassHealth Regulations and Other Publications link on [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Update to the Durable Medical Equipment and Oxygen Payment and Coverage Guideline Tool

In October 2006, MassHealth updated the durable medical equipment (DME) and

oxygen payment and coverage guideline tool. This online tool provides abbreviated descriptions for all DME and oxygen service codes covered by MassHealth, and identifies applicable modifiers, place-of-service codes, prior-authorization requirements, service limits, and pricing and mark-up information.

New features of the tool include the ability for users to scroll to the right of the Excel spreadsheet, and a new tool to assist with prior authorization (PA) and billing for enteral supplies. Now users can convert the number of calories per container to the number of units simply by clicking on "BA-Modifier-Calorie to Unit" at the top of the page, entering the number of calories per container, then pressing "enter."

The payment tool is accessible under the MassHealth Regulations and Other Publications section by clicking on Provider Library. The tool is listed at the bottom of the Web page.

## Automated Solutions: Electronic Funds Transfer

Great news! If you are interested in accessing reimbursement funds faster, reducing the administrative burden of processing checks, and/or avoiding the chance of checks getting lost or stolen, then Electronic Funds Transfer (EFT) is the answer. If you have not already signed up for EFT, what are you waiting for? Receiving your MassHealth payment has never been easier. Simply go to [www.mass.gov/masshealth](http://www.mass.gov/masshealth) to get your EFT application and start taking advantage of this best business practice.

### Why EFT?

EFT allows MassHealth to send your payments directly into your bank account, a huge benefit over the traditional paper-check system. In addition, you have more control over where you choose to receive your remittance advices. With paper checks, the remittance advice is sent to the same address where the checks are

received, regardless of your preference. If you elect EFT, your remittance advice can be sent to any address that you choose.

**Get your EFT application from the Provider Forms link on [www.mass.gov/masshealth](http://www.mass.gov/masshealth).**

### Sign Up Today

To start receiving deposits directly into your bank account, submit a signed copy of our EFT application. This application is accessible from the MassHealth Provider Forms link in the Publications box on the MassHealth home page. Just download and print out a paper copy of the form, and enter your banking details, such as bank routing number (ABA) and an account number. After completing the form, sign it

and attach a voided check, and mail it to:

MassHealth  
Attn: EFT  
P.O. Box 9118  
Hingham, MA 02043.

If you are unable to download the form from our Web site, you can contact MassHealth Customer Service at 1-800-841-2900 to request a faxed or mailed copy.

After all your information has been correctly submitted and processed by MassHealth, you will begin receiving deposits in 14 days. If you provided an e-mail address on your application, you will receive a confirmation e-mail once your application is approved.

Streamline your cash flow right now: go to [www.mass.gov/masshealth](http://www.mass.gov/masshealth) and sign up for EFT!

## Providers' FAQs: Using the 837 Transaction for Certain Claims

Using the 837 transaction to submit your claims to MassHealth offers the fastest, most efficient method of claims submission. The benefits of electronic submission far outweigh the comfort of paper submission. However, MassHealth has noticed that there is some confusion among the provider community for billing certain types of claims electronically, such as coordination of benefits (COB) claims, claims that require attachments, and Void and Replace requests.

**I need to submit a claim where the member also has other insurance in addition to MassHealth. Isn't it easier just to submit a paper claim along with the other insurer's explanation of benefits (EOB)?**

No! Actually, using the 837 transaction when billing for members with other insurance (also known as coordination of benefits or COB billing) is much easier than billing on paper. Once you have gone through testing and are approved to submit COB claims, simply enter the other insurer's information in the 837 transaction—no extra paperwork is needed, including not having to send a

copy of the other payer's EOB.

**If I have a claim that requires an attachment (for example, surgical notes), don't I have to submit it on paper?**

Not at all. Don't let an attachment stop you from using the 837 transaction. Simply use the 837 transaction to submit the claim and use the Claims Attachment Form (CAF). The CAF will automatically be sent to you once your claim is received by MassHealth. Just fill it out and return it to MassHealth with the required documentation with 45 days. It couldn't be easier!

**Do I have to submit an adjustment to a paid claim on paper, or can I use the electronic Void and Replace transaction to submit the adjustment?**

If you are approved to submit claims electronically, the Void and Replace transaction is the paperless way to adjust a previously paid claim electronically. Use the Void and Replace transaction to electronically void the paid claim, and submit the replacement claim referencing the former transaction control number.

If you are not approved to submit claims electronically, you would be required to follow the applicable paper-claim-adjustment procedures. Consult Subchapter 5 of your provider manual for more information about correcting claims.

**How do I know if a Transaction Control Number (TCN) is required?**

MassHealth has enhanced its claims-processing system to automatically search the claims-history database to confirm that the claim was initially submitted in a timely manner. A former TCN is not required if your paper claim meets the following criteria:

- the original claim was submitted within the 90-day period and appeared as denied on the remittance advice; and
- the member number (RID), pay-to-provider number, revenue code, service code, claim type, or service date is not changing.

## ■ New Dental Program Focused on Increasing Access to Dental Care *(continued from page 1)*

For dentists, this includes:

- a dedicated dental-provider-relations call center with standardized response times;
- a Web portal through which dentists can perform myriad transactions;
- a simple way to submit claims through the Internet;
- an intervention-services program designed to ensure that members keep their appointments;
- an office reference manual that will outline protocols for all claims-related activities, such as billing, prior

authorization, member-eligibility verification, and claims status;

- provider-education programs on a range of clinical topics; and
- continued ability to limit caseloads.

For members, this means:

- increased access to oral-health education, through DSM's proven outreach programs;
- customer-service representatives committed to timely, standardized response times;
- intervention specialists who provide

education on subjects such as proper dental-office procedures, the consequences of missed appointments, and good oral-hygiene practices; and

- an online directory for members to find dentists nearest to them.

As a result of these exciting enhancements, dentists and their staff can look forward to predictable, reliable administration. DSM staff looks forward to making MassHealth work successfully behind the scenes, so dentists can focus on their patients.

## ■ MassHealth Reminders

### Have you checked in with the MassHealth Feature of the Month?

The MassHealth Web site now includes a Feature of the Month. This Web page, located via a link in the News and Updates section, gives providers tips and information to help them improve their MassHealth billing procedures.

The December Feature of the Month will clear up the confusion around using the 837 transaction to simplify billing procedures for certain types of claims, such as coordination-of-benefits billing, claims with attachments, and 90-day waivers. Stay tuned to [www.mass.gov/masshealth](http://www.mass.gov/masshealth)!

### Transmittal Letter ALL-144

Transmittal Letter (TL) ALL-144 (December 2006) informs providers of updates to Appendix Y in all provider manuals. Changes to Appendix Y include additional Recipient Eligibility Verification System (REVS) messages as described below.

The following codes and messages will now appear in REVS, as applicable:

- 620: Member also eligible for Commonwealth Care. Member must enroll in managed care to receive these benefits. Call 1-877-MAENROLL.

The message will appear for members eligible to enroll in Commonwealth Care

but have not selected it for their Managed Care Organization (MCO) plan.

- 621: Member also eligible for Commonwealth Care. Enrolled with (Commonwealth Care MCO) plan. Coverage to begin <Mon06>.

This message will appear for members who have selected and been assigned to a Commonwealth Care MCO plan, but whose coverage is not yet active.

Additionally, another new message informs providers when the member has more than one member identification number (RID) entered in REVS to ensure the correct RID is used.

You can download TL ALL-144 from the Provider Library located under the MassHealth Regulations and Other Publications link on the MassHealth Web site. Click on Transmittal Letters, then 2006 Transmittal Letters.

### Provider Recredentialing

All Provider Bulletin 160 was issued in November 2006 to inform providers of the recredentialing project. MassHealth will recredential all providers over the next three years to verify the integrity of our provider file information. MassHealth will select a different one-third of the provider population each year for recredentialing.

Along with the one-third selected for full recredentialing review by June 30, 2007, MassHealth will perform an abbreviated review on the remaining two-thirds of providers.

The recredentialing project does not replace the requirement to report changes in provider information or status (such as address, contact details, licensure, etc.) to MassHealth in writing within 14 days.

You can download All Provider Bulletin 160 from the Provider Library located under the MassHealth Regulations and Other Publications link on [www.mass.gov/masshealth](http://www.mass.gov/masshealth). Click on Provider Bulletins, then 2006 Provider Bulletins.

### New Provider Billing Tip Flyers

In November, MassHealth added two new billing tips flyers to the MassHealth Web site: Electronic Claims Submission and Electronic Coordination of Benefits Billing. The flyers explain how you can incorporate these automated solutions to simplify your billing procedures.

You can access the new flyers from the Billing Tips section on [www.mass.gov/masshealth](http://www.mass.gov/masshealth). Click on the Information for MassHealth Providers link, then Customer Service for Providers, and then Billing Information.